TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Baylor Orthopedic & Spine Hospital

Respondent Name
TX Assoc of Counties RMP

MFDR Tracking Number
M4-18-0815-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
November 27, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Reimbursement was received in the amount of $15,286.24. A reconsideration was submitted for the additional due of $9,918.29."

Amount in Dispute: $9,918.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After review of the Request for Medical Fee Dispute Resolution, Careworks stands on the original denial for lack of Manufactures Cost Implant Invoice."

Response Submitted by: Careworks, 10535 Boyer Blvd, Suite 100, Austin, Texas 78758

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 17 - 18, 2017	DRG 483 Revenue Code 278	$18.29 $9,900.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensations jurisdictional fee schedule adjustment
   - 16 – Claim/service lacks information which is needed for adjudication. Remark codes whenever appropriate

- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
- W3 – Additional payment made on appeal/reconsideration

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule for determining reimbursement of the disputed services?
3. What is the recommended payment for the services in dispute?
4. Is an additional payment recommended for the implantable items in dispute?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking $9,918.29 for inpatient hospital services including implants provided on March 17 - 18, 2017. The insurance carrier denied disputed services with claim adjustment reason code 251 – "The attachment content received did not contain the content required to process this claim or service."

   28 Texas Administrative Code §134.404 (g) states in pertinent part,

   > Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

   Review of the submitted documentation found the following:
   - Itemized bill with revenue code 278 – Shoulder Primary Reverse, C1776, $9,000.00
   - Delivered Goods Order Form with total invoice price $9,124.00

   No other documents were found to support the line item and amount billed. Therefore, as no manufacturer's invoice was included with this dispute, the insurance carrier's denial reason is supported. The disputed services will be reviewed per applicable Division rules and fee guidelines.

2. This dispute relates to facility medical services provided in an inpatient acute care hospital. No documentation was found to support that the services are subject to a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011. Reimbursement is therefore subject to the provisions of 28 Texas Administrative Code §134.404(f), which states that:

   > The reimbursement calculation used for establishing the MAR [maximum allowable reimbursement] shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   > (A) 143 percent; unless
   > (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.

   Review of the submitted documentation finds that separate reimbursement for implantables was requested; for that reason, the MAR is calculated according to §134.404(f)(1)(B).

3. Per §134.404(f)(1)(B), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment by 108%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 483. The services were provided at Baylor Orthopedic and Spine. Based on the

submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $13,892.93. This amount multiplied by 108% results in a MAR of $15,004.36.

4. Additionally, the provider requested separate reimbursement of implantables. Per §134.404(g):

   Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

   Review of the submitted documentation finds that the separate implantable was:

   - Shoulder Primary Reverse

   No invoice was found to determine the cost of the reported implant. No additional reimbursement recommended.

5. The total recommended payment for the services in dispute is $15,004.36. The amount previously paid by the insurance carrier was $15,286.24. No additional payment is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		December 21, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.